

**Kentucky Department of Insurance**  
**External Review Decision Notification Form**

This form is to be used by an Independent Review Entity (IRE) to report external review (ER) decisions. The completed form must be sent to the insurer or private review and forwarded via regular mail or facsimile (502-564-2728) to the Division of Health Insurance Policy and Managed Care, P. O. Box 517, 215 West Main Street, Frankfort, KY 40602, within two (2) business days of rendering a decision. If you have any questions related to this form or to the notification process, please call 502-564-6088.

1. Name of IRE \_\_\_\_\_
2. Name of Insurer \_\_\_\_\_
3. Name of Covered Person \_\_\_\_\_
4. (a) Was a request for an extension of the timeframe for making an ER determination requested? ☐ Yes ☐ No  
(b) If an extension of the decision timeframe was requested, please provide reason for extension request:  
\_\_\_\_\_
5. Date and time the IRE received all information from the insurer related to the ER \_\_\_\_\_
6. Name and credentials for each external reviewer (including title, state of licensure, medical license number, if applicable, and any specialty board certifications): \_\_\_\_\_  
\_\_\_\_\_
7. Date and time the decision was rendered \_\_\_\_\_
8. Decision favored: ☐ Covered Person ☐ Insurer
9. Date and time the notification was issued:  
\_\_\_\_\_
10. Fee billed: \_\_\_\_\_
11. Was the \$25 filing fee collected from the covered person? ☐ Yes ☐ No  
If no, please indicate the reason ☐ Waived due to Financial Hardship  
☐ Decision in favor of Covered Person ☐ Other (Please explain) \_\_\_\_\_  
\_\_\_\_\_

Following are IRE records that shall accompany this form.

12. A copy of the actual decision letter issued by the IRE to the Covered Person, Authorized Person, Provider and Insurer;
13. Please identify the proposed service, treatment, drug, device, or supply for which the review was performed;
14. Please identify the relevant provisions in the insurer's health benefit plan and how applied;
15. Please identify the findings, studies, research, and other relevant documents of government agencies and nationally recognized organizations, relevant findings in peer-reviewed medical or scientific literature, published opinions of nationally recognized medical specialists, and clinical guidelines used as a basis for decision-making, the relevant provisions of any nationally recognized and peer-reviewed medical or scientific documents used in the external review; and
16. Please attach a copy of the "no conflict of interest" statement signed by each reviewer and a copy of each reviewer's analysis and recommendation relating to the external review.